UTAH CATASTROPHIC MENTAL HEALTH SURVEY INSTRUCTIONS

All Fraternal, Health, Life and Property & Casualty insurers in Utah who reported group comprehensive hospital & medical business in Utah during 1999, 2000, 2001, or 2002 are required to complete and file this survey. All other insurers are exempt. All forms necessary to complete the survey are available electronically at: http://www.insurance.utah.gov/hot.html. A copy of the completed survey form should be received by the Utah Insurance Department **by no later than October 17, 2003**. Submissions may also be made via email to jhawley@utah.gov. Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code Annotated (U.C.A.) § 31A-2-308. Any questions on completing this survey form should be directed to Jeff Hawley, Research Analyst at (801) 538-9684.

This survey is designed to collect data that will allow the Utah Insurance Department to evaluate the impact of Utah Code Annotated (U.C.A.) 31A-22-625 "Catastrophic coverage of mental health conditions" on Utah's commercial health insurance market. All data values reported on the survey form should represent the state of your company as of December 31 (year-end) of the report year.

Data is required for any year that your company had group comprehensive hospital & medical insurance (e.g., group major medical or group hospital & medical) during 1999, 2000, 2001, or 2002. You are required to submit one copy of the survey for each year of data. For the years your company did not have any group comprehensive hospital & medical insurance in Utah submit a copy of the completed survey for that year with "NONE" written on it. For example, if your company had group comprehensive hospital & medical insurance in Utah during 1999, 2000 and 2001, but no business in 2002, then four surveys should be submitted: three with data (report years 1999, 2000, and 2001) and one with "NONE" (report year 2002).

Your company was selected for participation in this survey because your company reported direct insured group comprehensive hospital & medical insurance in Utah during 1999, 2000, 2001, or 2002. Please note that direct insured business means business where the insurance company bears the underwriting risk prior to ceding or assumption and should include all Utah residents (even if your company wrote the policy in another state and the insured member later moved into Utah). It does not include any administrative only (e.g., ASO or ASC) or any type of self-funded business. The survey uses the same definition of "comprehensive hospital & medical insurance" as is used in the NAIC Financial Statement. Only data on group comprehensive hospital & medical insurance (e.g., group major medical or group hospital & medical) is needed. Therefore, all individual business or any group health insurance that does not meet the NAIC criteria for comprehensive hospital & medical (such as medical only, dental only, vision only, stop loss, disability income, credit A&H, long-term care, and Medicare supplement, as well as Medicare & Medicaid) should be excluded.

COLUMN DEFINITIONS

NO MENTAL HEALTH COVERAGE:	Comprehensive policies without any form of mental health coverage. No data is required other than membership, total drug claims, and total claims.
MENTAL HEALTH COVERAGE THROUGH EMPLOYER CARVE OUT:	Comprehensive policies with mental health which is provided by an employer (independent of the insurer) as an employer carve out. No data is required other than membership, total drug claims, and total claims.
FIFTY/FIFTY MENTAL HEALTH COVERAGE:	"Fifty/fifty mental health coverage" means coverage that pays for at least 50 percent of covered services for the diagnosis and treatment of mental health conditions (see also U.C.A. § 31A-22-625(1)(b)). "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised (see also U.C.A. § 31A-22-625(1)(d)). This category only applies to small group comprehensive policies, so no large group data should exist under this category.
CATASTROPHIC MENTAL HEALTH COVERAGE:	"Catastrophic mental health coverage" means coverage that does not impose any lifetime, annual, episodic, inpatient service, outpatient service, or maximum out of pocket limit that places a greater financial burden on an insured member for the evaluation and treatment of a mental health condition (see also U.C.A. § 31A-22-625(1)(a)). "Mental health condition" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised (see also U.C.A. § 31A-22-625(1)(d)). This category applies to both small and large group comprehensive policies.
MENTAL HEALTH EXCEEDS MINIMUM COVERAGE:	U.C.A. § 31A-22-625 allows insurers to offer coverage that exceeds the minimum requirements under Catastrophic and Fifty/Fifty mental health coverage. This category applies to both small and large group comprehensive policies.
TOTAL UNDER ALL COMPREHENSIVE POLICIES:	This category reports the total activity for all types of mental health coverage under all group comprehensive health insurance policies in Utah. On the survey form, this column should equal the sum total of columns I through V for each row. For example, the cumulative member months reported under columns I through V, when summed together, should equal column VI.

ROW DEFINITIONS

Membership:

NUMBER OF INSURED MEMBERS:	Enter the number of fully insured members for each mental health category. The number of insured members should equal the number of certificate holders plus dependents enrolled as of December 31 of the report year. For example, if there were 150 members who participated in your plan during the year, but only 100 members were currently enrolled as of December 31, report the number of insured members as 100.
NUMBER OF INSURED POLICIES:	Enter the number of fully insured policies for each mental health category. The number of group policies should equal the number of certificate holders (or individual contracts). For example, if there were 150 members enrolled under 3 employer contracts during the year, but only 100 members under 2 employer contracts were currently enrolled as of December 31, report the number of group policies as 2.
NUMBER OF INSURED EMPLOYERS:	Enter the number of employers who had a group health insurance contract under each mental health category. For example, if there were 12 employers under contract during the year, but only 10 employers were currently under contract as of December 31, report the number of insured employers as 10.
CUMULATIVE MEMBER MONTHS:	Enter the cumulative year-end member months for each mental health category. To calculate member months, first count the number of insured members during each month of the year. This produces 12 member counts (one for each month). Then sum total all 12 member counts. This total is the cumulative member months for the year. For example, if your company had 10 insured members during each of the 12 months of the year, the cumulative member months would be calculated as follows: 10 members x 12 months = 120 member months.

Inpatient Mental Health:

NUMBER OF INPATIENT DAYS:	Measure of inpatient mental health utilization. Includes all claims billed for mental health services at any acute care hospital/facility as part of an inpatient stay. This includes physician services, counseling, chemical dependency, and other forms of mental health treatments covered under the member's mental health benefit. Utilization is measured using the number of days stayed at the facility (not admissions) as defined by the number of dates of service. For example, if an insured member was admitted to the hospital for drug treatment on January 1, 2001 and was released on January 3, 2001, the number of admissions was one and the number of inpatient days was three.
INSURER PAID:	Enter the total dollar amount of the inpatient mental health claims that the insurance company is responsible for (after applying coinsurance, copays, or deductibles). This is what is usually defined as "paid claims" on the NAIC annual statement.
INSURED PAID:	Enter the total dollar amount of the inpatient mental health claims that the insured member is responsible for. This includes any coinsurance, copays, or deductibles. This is usually omitted from "paid claims" as defined by the NAIC annual statement (as the insurer does not pay this, the member does).

Outpatient Mental Health:

NUMBER OF OUTPATIENT VISITS:	Measure of outpatient mental health utilization. Includes all claims billed for mental health services performed in any outpatient setting. This includes physician services, counseling, chemical dependency, and other forms of mental health treatments covered under the insured member's mental health benefit. Utilization is measured by counting the number of unique dates of service. For example, each unique date of service equals one outpatient visit.
INSURER PAID:	Enter the total dollar amount of the outpatient mental health claims that the insurance company is responsible for (after applying coinsurance, copays, or deductibles). This is what is usually defined as "paid claims" on the NAIC annual statement.
INSURED PAID:	Enter the total dollar amount of the outpatient mental health claims that the insured member is responsible for. This includes any coinsurance, copays, or deductibles. This is usually omitted from "paid claims" as defined by the NAIC annual statement (as the insurer does not pay this, the member does).

Drugs Prescribed By Mental Health Providers:

NUMBER OF SCRIPTS:	Measure of mental health drug utilization. Utilization is measured by counting the number of prescriptions (count one script per unique date of service regardless of pill count or volume) written by mental health providers under the insured member's prescription drug benefit. For example, suppose an insured member received 4 prescriptions (each one for a three month supply) from a mental health provider (e.g., psychiatrist) and 10 prescriptions (each one for a one month supply) from a non-mental health provider (e.g., family practice physician) during the year. For the purposes of the survey, the number of prescriptions would be 4 scripts. Use your existing provider codes and categories to identify whether a provider is a mental health provider or not. If you do not have a category already in place, you may contact the department for assistance.
INSURER PAID:	Enter the total dollar amount of the drugs prescribed by mental health providers that the insurance company is responsible for (after applying coinsurance, copays, or deductibles). This is what is usually defined as "paid claims" on the NAIC annual statement.
INSURED PAID:	Enter the total dollar amount of the drugs prescribed by mental health providers that the insured member is responsible for. This includes any coinsurance, copays, or deductibles. This is usually omitted from "paid claims" as defined by the NAIC annual statement (as the insurer does not pay this, the member does).

Total Drug Claims Under Comprehensive Policies:

NUMBER OF SCRIPTS:	Measure of comprehensive drug utilization. Utilization is measured by counting the number of prescriptions (count one script per unique date of service regardless of pill count or volume) written by all health providers under the insured member's prescription drug benefit.
INSURER PAID:	Enter the total dollar amount of the drug claims under all comprehensive health insurance policies that the insurance company is responsible for (after applying coinsurance, copays, or deductibles). This is what is usually defined as "paid claims" on the NAIC annual statement.
INSURED PAID:	Enter the total dollar amount of the drug claims under all comprehensive health insurance policies that the insured member is responsible for. This includes any coinsurance, copays, or deductibles. This is usually omitted from "paid claims" as defined by the NAIC annual statement (as the insurer does not pay this, the member does).

Total Claims Under Comprehensive Policies:

INSURER PAID:	The total dollar amount of all claims under comprehensive health insurance policies that the insurance company is responsible for (after applying coinsurance, copays, or deductibles). This is what is usually defined as "paid claims" on the NAIC annual statement.
INSURED PAID:	The total dollar amount of all claims under comprehensive health insurance policies that the insured member submitting the claim is responsible for. This includes any coinsurance, copays, or deductibles. This is usually omitted from "paid claims" as defined by the NAIC annual statement (as the insurer does not pay this, the member does).

Provider Network:

NUMBER OF MENTAL HEALTH PROVIDERS:	Enter the number of mental health providers under contract in your comprehensive health insurance provider network. For example, if there were 100 health providers under contract in your provider network as of December 31 and 10 providers specialized in mental health, report the number of mental health providers as 10.
TOTAL NUMBER OF HEALTH PROVIDERS:	Enter the total number of health providers (all types) under contract in your comprehensive health insurance provider network. For example, if there were 100 health providers under contract in your provider network as of December 31 and 10 providers specialized in mental health, report the number of health providers as 100.